DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH AND RECOVERY SERVICES ADMINISTRATION
Olympia, Washington

To:	All Providers Managed Care Organizations	**Memorandum No: 06-04** **Issued:** February 6, 2006
From:	Douglas Porter, Assistant Secretary Health and Recovery Services Administration (HRSA)	**For information, contact:** 800.562.3022

Subject: Update HCFA-1500 Claim Form Instructions and page updates for the General Information Booklet.

The Health and Recovery Services Administration (HRSA) has updated the instructions for completing paper copies of the HCFA-1500/CMS-1500 and is adding a new section to the General Information booklet on "How to Complete a HCFA Claim Form".

Claim Form (HCFA-1500 or CMS-1500)

Note: The Health Insurance Claim Form is now officially called the "CMS-1500". Providers can order and purchase "CMS-1500", formerly called "HCFA-1500", forms on-line from many office supply stores. Because HRSA's billing instructions still refer to the claim form as "HCFA-1500", HRSA will continue to use the terms "HCFA-1500" and "CMS-1500" interchangeably until all of the billing instructions are updated.

HRSA uses Optical Character Recognition (OCR) equipment to process paper claim forms. **Use only the original pre-printed red and white CMS-1500 claim forms** (version 12/90 or later, preferable on 20# paper). The CMS-1500 form is designed specifically for OCR systems. The scanner does not read black and white (copied, carbon, or laser-printer generated) CMS-1500 claim forms.

Most of HRSA's billing instructions include a "How to Complete the HCFA-1500 Claim Form" section. HRSA periodically revises this section according to ongoing system changes. This memorandum introduces a number of updates to this section for certain fields on the claim form. HRSA will incorporate these updates into specific program billing instructions as these billing instructions are reviewed and revised.

Refer to HRSA's specific program billing instructions for requirements in addition to those below for completing the HCFA-1500 or CMS-1500 form for your specific program.

Updated Claim Form Fields

Field 17a – ID Number of Referring Physician

If a referring provider does not have an HRSA-assigned ID number, enter **8900946** into Field 17a. Use this standard number **only** for referring providers who are non-Medicaid referring providers. Providers can find more information by visiting the Provider Number Reference web site: https://fortress.wa.gov/dshs/pnrmaa/Login.aspx?ReturnUrl=%2fDefault.aspx.

Field 19 – Reserved for Local Use

Use Field 19 for comments that require a claims specialist to review a claim before payment is made. Inappropriate comments in this field may result in delayed processing of claims.

Examples of **appropriate** comments include the following:

- "B" for baby on a parent's PIC;
- "Twin A" or "twin B";
- "Triplet A", "triplet B", or "triplet C";
- "ITA client" (Involuntary Treatment Act client);
- "NDC" (National Drug Codes); and
- "Backup attached".

Field 24D – Procedures, Services, or Supplies CPT/HCPCS

When appropriate, providers enter a modifier in this Field 24D. If there is more than one modifier, list them in descending numerical order. For example:

99 80 59

Field 24E – Diagnosis Code

Enter the valid ICD-9-CM diagnosis code exactly as shown in the current volume of the ICD-9-CM manual, or relate each line item to Field 21 by entering a 1, 2, 3, or 4. Enter the principal diagnosis as the first diagnosis code. Providers must follow additional digital requirements found in the ICD-9-CM manual.

Field 26 - Patient Account Number

Providers create this number. HRSA prints the characters entered in Field 26 on *Remittance and Status Report (RA)* under the heading *Patient Account Number*. **If providers use symbols in Field 26 (on paper or electronic claims) this may invalidate an electronic RA**.

To ensure correct processing of an electronic RA, do not use spaces or the following characters in Field 26:

***** (asterisk)
~ (tilde)
: (colon)

Field 30 – Balance Due

Calculating the *estimated payment due:*

- Results in faster adjudication and fewer rebilled claims; and
- Aligns HRSA's payment policy with other third-party payers.

HRSA automatically calculates the *estimated payment due* for physician, dental, and institutional claims (excluding Medicare crossover claims). HRSA calculates this amount on both electronic and paper claims. This calculation takes place when the *estimated payment due* is either missing or not calculated correctly on the claim form and providers indicate one of the following:

- Third-party payments;
- Patient spenddown (if applicable); and
- Noncovered charges on the claim form.

Providers must indicate the total charges on the claim and use the claim form specified in the specific program's billing instructions.

- **Place only six detail lines on each claim form**. HRSA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Total each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form. Do not indicate "continued" on claim forms.

If the provider does not include or miscalculates the total charges on the claim form, HRSA will deny the claim.

Field 33 - PIN #

HRSA assigns this 7-digit number to identify the performing individual (e.g., the physician or Advanced Registered Nurse Practitioner who performed the service) when the individual is part of a group, such as a clinic, which has its own assigned provider numbers for billing purposes.

General Information Booklet New Replacement Pages

Attached are updated and new *General Information Booklet* pages i - iv and H.11-H.18.

How do I conduct business electronically with HRSA?

You may conduct business electronically with HRSA by accessing the WAMedWeb at http://wamedweb.acs-inc.com.

How can I get HRSA's provider issuances?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

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How to Complete the HCFA-1500 Claim Form

Note: HRSA encourages providers to make use of electronic billing options. For information about electronic billing, refer to the *Important Contacts* section

The CMS-1500, HCFA-1500, U2, 12-90, or the Health Insurance Claim Form is a universal claim form. The numbered boxes on the claim form are referred to as fields. A number of the fields on the form do not apply when billing HRSA. Some field titles may not reflect their usage for a particular claim type.

If you do not follow these instructions, your claims may be denied or suspended for further processing, also known as adjudication. Either one of these actions will extend the time period for payment.

Guidelines/Instructions for Paper Claim Submission:

- In order for the claim to be read by the OCR, red ink on the blank claim form must be either Sinclair Valentine J6983 or OCR Red Paper. Paper claims must be submitted using these scannable red inks. These inks cannot be duplicated by a computer printer.
- **Do not use red ink pens, highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" or similar statements on claim form.
- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch). Do not mix character fonts on the same claim form. Do not use italics or script.
- **Use upper case** (capital letters) for all alpha characters.
- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not faded or too light!**
- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.
- **Place only six detail lines on each claim form**. HRSA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.
- **Total each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form. Do not indicate "continued" on claim forms.

HCFA 1500 Field Descriptions

Field No.	Name	Field Required	Entry
1a.	**Insured's ID No.**	Yes	Enter the Patient Identification Code (PIC) – an alphanumeric code assigned to each HRSA client – exactly as shown on the Medical ID card which consists of the client's: • First and middle initials (a dash [-] *must* be used if the middle initial is not available). • Six-digit birthdate, consisting of *numerals only* (MMDDYY). • First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker. • An alpha or numeric character (tiebreaker). • Apostrophes, hyphens and other special characters in a last name are valid and take the place of a letter. *For example:* ➢ Mary C. Johnson's PIC looks like this: MC010667JOHNSB. ➢ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B ➢ John O'Henry's PIC looks like this: J-102564O'HENA.
2.	**Patient's Name**	Yes	Enter the last name, first name, and middle initial of the client (the receiver of the services for whom you are billing).
3.	**Patient's Birthdate**	Yes	Enter the birthdate of the client.
4.	**Insured's Name (Last Name, First Name, Middle Initial)**		When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, TRI-CARE, or TRI-CAREVA) enter the name of the insured here. Enter the name of the insured except when the insured and the client are the same – then the word *Same* may be entered.
5.	**Patient's Address**	Yes	Enter the address of the client who received the services you are billing for (the person whose name is in Field **2**.)

Field No.	Name	Field Required	Entry
9.	**Other Insured's Name**		If there is other (secondary) insurance (Field 11d), enter the last name, first name and middle initial of the person who holds the other insurance. If the client has other insurance and this field is not completed, payment of the claim may be denied or delayed.
9a.	**Other Insured's Policy or Group Number**		Enter the other insured's policy or group number *and* insured's SSN.
9b.	**Other Insured's Date of Birth and Gender**		Enter the other insured's date of birth and gender.
9c.	**Employer's Name or School Name**		Enter the other insured's employer's name or school name.
9d.	**Insurance Plan Name or Program Name**		Enter the insurance plan name or program name (e.g., the insured's health maintenance organization, private supplementary insurance). **Please note:** DSHS, Medicaid, Welfare, Provider Services, Healthy Options, First Steps, and Medicare, etc., are **inappropriate** entries for this field.
10.	**Patient's Condition Related To**	Yes	Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in Field **24**. ***Indicate the name of the coverage source in field*** **10d** (L&I, name of insurance company, etc.).
11.	**Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**		Primary insurance, when applicable. This information applies to the insured person listed in Field **4**. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid is the payer of last resort.
11a.	**Insured's Date of Birth**		Primary insurance. When applicable, enter the insured's birthdate, if different from Field **3**.
11b.	**Employer's Name or School Name**		Primary insurance. When applicable, enter the insured's employer's name or school name.
11c.	**Insurance Plan Name or Program Name**		Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(***Note***: This may or may not be associated with a group plan.)*

Field No.	Name	Field Required	Entry
11d.	**Is there another Health Benefit Plan?**	Yes if secondary insurance.	Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed Fields **9a.-d**. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.
17.	**Name of Referring Physician or Other Source**		When applicable, enter the referring physician or Primary Care Case Manager (PCCM) name.
17a.	**ID Number of Referring Physician**		When applicable, 1) enter the 7-digit HRSA-assigned physician number. Refer to the Provider Number Reference website: https://fortress.wa.gov/dshs/pnrmaa/Login.aspx?ReturnUrl=%2fDefault.aspx; 2) If the referring provider does not have an HRSA-assigned ID number, enter 8900946. Use this standard number **only** for referring providers who do not have an HRSA assigned ID number; or 3) When the PCCM referred the service, enter his/her 7-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this Field when you bill HRSA, the claim will be denied.
19.	**Reserved for Local Use**		This field is used for comments that require an HRSA claims specialist to review a claim before payment is made. Examples of appropriate comments: • "B" for baby on a parent's PIC • "Twin A" or "twin B" • "Triplet A", "triplet B", or "triplet C" • "ITA client" • "NDC" • "backup attached" Inappropriate comments may result in delayed processing of claims.
21.	**Diagnosis or Nature of Illness or Injury**		Enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.
22.	**Medicaid Resubmission**		When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the *Remittance and Status Report*.)

Field No.	Name	Field Required	Entry
23.	**Prior Authorization Number**		When applicable. If the service or hardware you are billing for requires prior authorization, enter the assigned 9-digit number. (See Field **24K** for Expedited Prior Authorization (EPA) numbers).

Field No.	Name	Field Required	Entry
24.	**Enter only one (1) procedure code per detail line (Fields *24A - 24K*).** If you need to bill more than 6 lines per claim, please use an additional HCFA-1500 claim form.		
24a.	**Date(s) of Service**	Yes	Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., June 04, 2005 = 060405).
24b.	**Place of Service**	Yes	Enter the appropriate **two digit** code as follows: **Code Number** — **To Be Used For** 11 — Office 31 — Skilled Nursing Facility 32 — Nursing Facility
24d.	**Procedures, Services or Supplies CPT/HCPCS**	Yes	Enter the appropriate procedure code for the service(s) being billed. Modifier: **When appropriate enter a modifier**. If there is more than one modifier, begin the list of modifiers with "99" (e.g., 99 80 59)
24e.	**Diagnosis Code**	Yes	Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in **24D**). A valid diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume or relate each line item to Field 21 by entering a 1, 2, 3, or 4. The first diagnosis should be the principle diagnosis. Follow additional digit requirements per ICD-9-CM.
24f.	**$ Charges**	Yes	Enter your usual and customary charge for the service performed. If billing for more than one unit, enter the total charge of the units being billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.
24g.	**Days or Units**	Yes	Enter the total number of days or units (up to 999) for each line. These figures must be whole units.
24k.	**Reserved for Local Use**		When applicable. Enter the required 9-digit EPA number only on the detail line to which the EPA number specifically applies.
25.	**Federal Tax ID Number**		Leave this field blank.

Field No.	Name	Field Required	Entry
26.	**Patient's Account Number**		Not required (optional field for internal purposes). Enter an alpha or numeric character only. For example, a medical record number or patient account number. Do not enter spaces or the following characters in this field: ***** (asterisk) **~** (tilde) **:** (colon) This number will be printed on your *Remittance and Status Report (RA)* under the heading *Patient Account Number*.
28.	**Total Charge**	Yes	Enter the sum of all charges indicated in Field 24F. Do not use dollar signs or decimals in this field.
29.	**Amount Paid**		If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from a source(s) other than insurance, specify the source in Field **10d**. Do not use dollar signs or decimals in this field or put prior Medicare or Medicaid payments here.
30.	**Balance Due**	Yes	Enter total charges minus any amount(s) in Field **29**. Do not use dollar signs or decimals in this field.
33.	**Physician's, Supplier's Billing Name, Address, Zip Code And Phone #**	Yes	Enter the provider's *Name* and *Address* on all claim forms. **PIN #**: This is the seven-digit number assigned by HRSA to identify the performing individual when the individual is part of a group (e.g., the MD/ARNP, etc. who performed the service). **Grp #**: This is the seven-digit number assigned by HRSA to the billing entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made to this number. **Note**: **When billing a Grp#, you must include a performing provider number in the PIN# field.**

For questions regarding claims information, call HRSA toll-free:

1-800-562-3022

Sample HCFA-1500 Claim Form(s)

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